



ARIZONA REGULATORY BOARD OF PHYSICIAN ASSISTANTS INITIAL LICENSE APPLICATION

9545 E Doubletree Ranch Rd., Scottsdale, AZ 85258
Phone: 480-551-2700 Fax: 480-551-2707

PHYSICIAN ASSISTANT APPLICATION INSTRUCTIONS

An Application for licensure as a physician assistant and the accompanying materials are included with this document. Please read all instructions carefully, noting that it is **YOUR RESPONSIBILITY** for ensuring verification of your physician assistant training, PANCE certification and experience. Please be sure all documents are forwarded directly to the Licensing Division of the Arizona Regulatory Board of Physician Assistants ("P.A. Board") at the address above. Applicants are required to comply with the current statutes and rules at the time they submit their application and should licensure be granted.

FOR YOUR INFORMATION: All credentials submitted shall remain the property of the P.A. Board and will not be returned. An application will not be considered for approval until all requisite forms and supporting documentation are in hand, **which is your responsibility.**

All forms provided in the application must be completed by the appropriate entity and returned directly to the P.A. Board's office.

Failure to submit a completed application within one year from the date of the board's mailing to the applicant of a statement of application deficiencies will result in your application being withdrawn. A complete application includes **ALL** forms, documentation, examination scores, verifications, etc., requested by the board, submitted in a form satisfactory to the board. Therefore, an application is not considered complete (even though the application form itself is completed) until ALL of the requested information has been received by the Licensing Division. **A.R.S. § 32-2522 (G)**

PLEASE NOTE THAT APPLICATION FEES ARE NOT REFUNDABLE.

Your interest in licensure in Arizona is appreciated and the Licensing Department looks forward to working with you to successfully complete this process. Should you have any questions, please do not hesitate to contact the P.A. Board Licensing Department staff at 480-551-2700. Also, for further information you may visit our website at www.azpa.gov

PLEASE NOTE: A Physician Assistant may not perform health care tasks in Arizona until your PA license is issued and you have a written delegation agreement with your supervising physician.

In addition to the appropriate completion of this application, the following must be submitted: (Please see the attached checklist for all documents needed)

1. Evidence of legal name and date of birth: U. S. *Birth Certificate*, U. S. Passport, Naturalization Certificate, Permanent resident card, Visa or legal status (see statement of citizenship form on website for list of accepted documents).
2. Evidence of legal name change other than that shown on documents filed in accordance with #1 above, i.e., marriage certificate.
3. Submit all forms included with the application that are applicable and that are listed on the checklist.
4. Submit a check, money order, or the attached payment card authorization for the \$125.00 non-refundable application fee. Should your application be approved, you will also be **invoiced for a prorated licensing fee.**



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INITIAL LICENSE APPLICATION

To be completed and signed by applicant. All questions MUST be answered, even if only to indicate "None" or "N/A."

1. **First Name:** **Middle Name:** **Last Name:**

Other Names Used:

2. **Social Security Number:** *No dashes* 3. **Date of Birth:**

4. **City of Birth:** OR **Country of Birth:**

Social Security Number, Date of Birth and Place of Birth are Confidential Information - Not for Public Disclosure

ADDRESSES:

Office Address: This is the licensee's primary practice location. The address and phone number will appear in the Medical Directory and on the Board's web site. Every physician assistant must have an address available to the public. If only one address is provided, even if it is your home address, it will be available to the public upon request.

Mailing Address: Please provide a mailing address if different from Office or Home Address. If no address is provided, all Board correspondence will be sent to the Office Address.

Home Address: You are required to provide a home address and telephone number. They will not be released to the public *unless* you fail to provide an Office Address.

Email: This address is optional. If you provide an email address, it will not be released to the public.

5. **Office/Training Name:**

Office/Training Address: **City:** **State:** **Zip:**

Office Phone: **Office Fax:**

Mailing Address: **City:** **State:** **Zip:**

Email Address:

Home Address: **City:** **State:** **Zip:**

Home Phone: **Mobile Phone:**

6. Physician Assistant Training Program Attended:

Location :

Degree Date:

7. In what states or provinces have you ever been granted any licensure as a physician assistant? If more than three, attach separate listing. If none please indicate " not applicable".

a. State Board: License No. : License Status:

b. State Board: License No. : License Status:

c. State Board: License No. : License Status:

8. Date of Physician Assistant National Certifying examination (PANCE or most recent recertifying examination (PANRE) :

9. **Have you been in continuous practice as a PA for the past 10 years (or since graduation from PA school)?**
(If you mark "No," please submit a narrative explaining any lapses in practice (i.e. preparing for PANCE, waiting for licensure, etc.)

☐ Yes

☐ No

Explanation:

First Name:

Last Name :

QUESTIONNAIRE

1. Have you had any application for any professional license refused or denied by any licensing authority? ☐ Yes ☐ No
-
2. Have you been refused or denied the privilege of taking an examination required for any professional licensure? ☐ Yes ☐ No
-
3. Have you been dropped, suspended, placed on probation, expelled, fined, resigned or been requested to resign from any medical school or post secondary educational program in which you were enrolled? ☐ Yes ☐ No
-
4. Has any training program taken action against you including probation, restriction, suspension, revocation, modification, accepted resignation, asked you to leave temporarily or permanently? ☐ Yes ☐ No
-
5. Have you voluntarily surrendered any healthcare license? ☐ Yes ☐ No
-
6. Have you had any healthcare license revoked? ☐ Yes ☐ No
-
7. Have you been the subject of disciplinary action or are you currently under investigation with regard to your healthcare license, have you been sanctioned by any healthcare licensing authority, healthcare association, license healthcare facility or healthcare staff of such facility? ☐ Yes ☐ No
-
8. Have your privileges been restricted, terminated, voluntarily or involuntarily resigned or withdrawn by any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility? ☐ Yes ☐ No
-
9. Has disciplinary action been taken against you by any licensing agency with regard to any professional license? "Disciplinary Action" includes, but is not limited to restriction, termination, voluntary or involuntary resignation or withdrawn. ☐ Yes ☐ No
-
10. Are there any pending complaints, investigations, or disciplinary actions against you with any healthcare licensing authority, healthcare association, licensed healthcare facility or healthcare staff of such facility? ☐ Yes ☐ No
-
11. Have you had a registration issued by a controlled substance authority (State or Federal) revoked, suspended, limited, restricted, modified, denied, or have you surrendered or given up in lieu of action? ☐ Yes ☐ No
-
12. Have you been charged with or convicted, pardoned or had a record expunged or vacated of a felony, or misdemeanor involving moral turpitude? (See explanation below) A "yes" answer is required even if you entered a diversion program. ☐ Yes ☐ No
-
13. Have you been charged with or convicted (including a nolo contendere plea or guilty plea) of a violation of any federal or state drug law(s) or rule(s) whether or not the sentence was imposed or suspended? ☐ Yes ☐ No
-
14. In the last ten (10) years, has a judgment or settlement been entered against you in excess of \$20,000 as a defendant in a medical malpractice suit? Please do not report pending malpractice suits or settlements paid not related to a civil action ☐ Yes ☐ No
-
15. Have you been court martialled or discharged other than honorably from the armed service? ☐ Yes ☐ No
-
16. Have you been terminated from a healthcare position with a city, county, or state government or the Federal government? ☐ Yes ☐ No
-
17. Have you ever been convicted of insurance fraud or received sanctions, including restrictions, suspension or removal from practice, imposed by any agency of the Federal government? ☐ Yes ☐ No

NOTE: In the event that the response to any of the questions above is "Yes," you must file with the application a detailed report concerning the above matters, including any charge, date of such charge, the complete name and address of all bodies of jurisdiction, the result of any hearings, and the disposition of such matters. In addition, you must submit photocopies of any corresponding documents, such as complaints or board actions.

Moral Turpitude includes but is not limited to the following: Armed Robbery, Assault with a Deadly Weapon, Attempted Insurance Fraud, Fabricating and Presenting False Public Claims, False Reporting to Law Enforcement Agency, Falsification of Records of the Court, Forgery, Fraud, Hit & Run, Illegal Sale and Trafficking in Controlled Substances, Indecent Exposure, Kidnapping, Larceny, Mann Act (Federal Commercialization of Women Statute), Misleading Sale of Securities in Connection with transfer of Real Property, Perjury, Possession of Heroin for Sale/Unlawful Sale or Dispensing Narcotic Drugs, Rape, Shoplifting and Soliciting Prostitution.

First Name:

Last Name :

CONFIDENTIAL QUESTIONNAIRE

1. Within the last five years, have you been diagnosed, treated or admitted to a hospital or other facility for the treatment of bi-polar disorder, schizophrenia, paranoia or any psychotic disorder?

☐ Yes ☐ No

2. Are you now being treated or have you in the last five years been treated for a drug or alcohol addiction or participated in a rehabilitation program? ***If in a confidential program in another state see explanation below.**

☐ Yes ☐ No

3. Do you currently have any disease or condition that interferes with your ability to competently and safely perform the essential functions of your profession, include any disease or condition generally regarded as chronic by the medical community, i.e. (1) behavioral health illness or condition; (2) alcohol or other substance abuse; and/or (3) physical disease or condition, that may presently interfere with your ability to competently and safely perform the essential functions involved in your usual practice?

☐ Yes ☐ No

Ability to practice medicine is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments.
2. The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

NOTE: In the event that the response to any of the questions above is "Yes," you must file with the application a detailed written narrative statement concerning the above matter(s), including the name of healthcare providers and treatment centers where you were treated, along with the discharge summary of your treatment and progress. If you are currently participating or have participated in the past 5 years, pursuant to a confidential agreement or order in a program for the treatment and rehabilitation of doctors of medicine impaired by alcohol, drug abuse or for other issues, please submit a copy of the agreement/order along with compliance reports from the state monitoring programs.

Failure to properly answer these questions can result in Board disciplinary action, including revocation or denial of license.

First Name :

Last Name :

The applicant

(Print or type Name)

being first duly sworn upon his oath deposes and says that I am the person above described and identified; that I have not engaged in any of the acts prohibited by the statutes of the State of Arizona, particularly those acts set forth in the Rules and Regulations of the Board.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentality's (local, state, federal or foreign) to release directly to the Arizona P.A. Board, all information, files, records requested by the P.A. Board in connection with the processing of this application. I further authorize the P.A. Board to release to the organizations, individuals and groups listed above any information which is material to my application. I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. I am the lawful holder of all credentials submitted and that the credentials submitted were not procured by fraud or misrepresentation or any mistake of which I am aware. Should I furnish false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my License to perform health care tasks as a physician assistant in the State of Arizona.

PROOF OF CITIZENSHIP: Effective January 1, 2008, based on Federal and State laws, all applicants must provide evidence that the applicant is lawfully present in the United States. Federal law, 8 U.S.C. §1641 and State law, A.R.S. §1-501, require documentation of citizenship or alien status for licensure. If the documentation does not demonstrate that the applicant is a United States citizen, national, or a person described in specific categories, the applicant will not be eligible for licensure in Arizona. Statement of Citizenship and Alien Status available on the website.

- ☐ **I am a U.S. Citizen or U.S. National.** (If this box is checked, please submit with your application a copy of one of the listed approved supporting documents listed in the "Arizona Statement of Citizenship and Alien Status for State Public Benefits" i.e. Birth Certificate, U.S. Passport, etc.)
- ☐ **I am NOT a U.S. Citizen or U.S. National.** (If this box is checked, you must download, complete and submit with your application an "Arizona Statement of Citizenship and Alien Status for State Public Benefits" form along with a copy of one of the listed approved supporting documents, such as an Alien Registration Card, Visa, etc.)

NOTE: Arizona law requires an applicant who has been charged with a felony or a misdemeanor involving conduct that may affect patient safety after submitting the application to notify the Board within 10 days after the charge is filed. A.R.S. §32-3208. For a list of reportable misdemeanors, see the website under Physician Center - Reportable Misdemeanors. All felonies are reportable.

First Name :

Last Name :

Signature :

Date:

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PHYSICIAN ASSISTANT APPLICATION CHECKLIST

If you are applying for a **PHYSICIAN ASSISTANT LICENSE**, please submit all items listed below.

Applications submitted without the application fee will not be accepted or processed until the fee has been received. Your application cannot be approved until **ALL** documentation has been received.

Failure to submit a completed application within one year from the date of the mailing by the board of a statement to the applicant of the deficiencies in the application pursuant to subsection E, will result in your application being withdrawn.

A.R.S. § 32-2522(G)

Application fees are non-refundable.

The following items are to be completed and forwarded to the board.

☐ **\$125.00** Application Fee (Upon approval you will be invoiced a pro-rated initial licensing fee up to \$185.00)

☐ Complete Application

☐ Evidence of Legal Name & Legal Status in the US

ie: Birth Certificate , Passport , Permanent Resident Card, Visa, Marriage License/Legal Name Change Documents

☐ Employment List of all physician assistant employment held since graduation or during the past five years

Detailed written narrative statement if you answered YES to any question on the application and accompanying documentation.

☐ (Including Malpractice form if applicable)

The applicant must forward the following enclosed forms to the appropriate entity for completion. (If applicable)

(When completed by the entity, these are to be sent directly to the Arizona Regulatory Board of Physician Assistants.)

☐ Form I to be completed and submitted by your P.A. Program;

☐ Authorize the N.C.C.P.A. to release your Physician Assistant National Certifying Examination (PANCE) or PANRE scores directly to the P.A Board.

If you are approved for licensure you will be invoiced the pro-rated licensure fee which is in addition to the application fee.

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FORM I - PHYSICIAN ASSISTANT TRAINING PROGRAM CERTIFICATION

Part of the application for certification as a physician assistant in the State of Arizona requires this form to be completed by the physician assistant training program where the physician assistant applicant received training as a physician assistant. The physician assistant applicant must forward this form for completion by an officer of the physician assistant training program which granted the physician assistant's degree. This completed form can then be faxed or mailed to the Board.

I hereby authorize the release of all information in your files, favorable or otherwise, directly to: The Arizona Regulatory Board of Physician Assistants, 9545 E. Doubletree Ranch Road, Scottsdale, Arizona 85258.

| | |
|---|--|
| Physician Assistant Signature: <input style="width: 90%;" type="text"/> | Physician Assistant Name: <input style="width: 90%;" type="text"/> |
|---|--|

To Be Completed by the Physician Assistant Training Program:

This is to certify that (name of applicant) was granted the degree of
 on
Dates attended : from to

1. Was the student ever required to repeat any segment of training? ☐ Yes ☐ No
2. Were any actions, restrictions, limitation (including probation or academic probation) taken while the student was participating in your training program? ☐ Yes ☐ No
3. Was the student ever counseled regarding his/her performance or behavior in your training program? ☐ Yes ☐ No
4. Were the student's final evaluations in every category rated satisfactory and/or above? Yes No ☐ Yes ☐ No
If No, please attach a photocopy of the evaluation and a written explanation.
5. Did the student have any medical condition which in any way impairs or limits his/her ability to safely practice any type of health care tasks within the scope of the physician assistant? ☐ Yes ☐ No

Ability to practice medicine is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reason medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other healthcare providers, with or without the use of aids or devices, such as a voice amplifier; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

Signature:

Name & Title:

P.A. Program Name :

Address:

Phone : Fax :

(Seal of Training Program)
(If none, indicate so)

Date:

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PHYSICIAN ASSISTANT EMPLOYMENT LIST

APPLICANTS: List all current and/or previous employment with medical agencies/supervising physicians, i.e., physician assistant placement group, private practice, hospital, clinic, etc., for the past five (5) years, and return this form with your application.

If you have been in the military since graduating from a P.A. Program, do not have an Agency of Employment/Supervising Physician form completed. Have your Commanding Officer submit a letter providing the dates of active duty and anticipated date of release, along with a summary of your duties.

Physician Assistant Applicant's Name :

Agency/Supervising Physician Name :

Address :

City :

State :

Zip :

Dates of Employment : From :

To :

Agency/Supervising Physician Name :

Address :

City :

State :

Zip :

Dates of Employment : From :

To :

Agency/Supervising Physician Name :

Address :

City :

State :

Zip :

Dates of Employment : From :

To :

Agency/Supervising Physician Name :

Address :

City :

State :

Zip :

Dates of Employment : From :

To :

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MALPRACTICE ADDENDUM

The applicant must complete this form for each malpractice settlement or judgment in the last ten (10) years. If more than one case, please make copies of this form and return with required documents. Please report only the settlement of a civil action.

First Name : Last Name :

1. Have you had more than one malpractice settlement/judgment in the past 10 years? ☐ Yes ☐ No

If "Yes," please continue with the remaining questions on this addendum.

If "No," please skip to bottom of page and sign and date the addendum. No further information needed at this time.

2. On a separate sheet of paper type your full name and provide a **detailed clinical narrative** regarding each malpractice case(s). Include name of patient, age, sex, date of occurrence and location (include address). Do not omit the answers to these questions or make reference to attached documents for answers. This section must be completed with your **own description** that includes all of the facts requested above. **NOTE:** HIPAA regulations do not prevent you from responding and providing the requested information.

3. What was the amount and date of the judgment or settlement? Amount: Date:

4. Amount of judgment or settlement attributed to you :

5. Has this case been investigated or reviewed by any State Medical Board? ☐ Yes ☐ No

If answer is "Yes", **request letter of resolution from State Medical Board be sent directly to us.** You do not need to attach the documents listed below if the case has been investigated or reviewed by any State Medical Board.

You are required to attach the following for each case :

☐ Copy of plaintiff's complaint

☐ Copy of Judgement or Settlement Agreement

☐ Copy of complete set of medical records including x-rays or diagnostic films

* X-rays and diagnostic films must be included. Your application cannot be processed without them.

I certify that the information which I have provided is correct to the best of my knowledge.

Signature :

Date:

Your application is not administratively complete until all documents are received.

PAYMENT CARD AUTHORIZATION
PHYSICIAN ASSISTANT LICENSE APPLICATION FEE

Payment for:

First name:

Last name:

Application Processing Fee \$125

Type of Card:

☐ Visa

☐ Mastercard

☐ Amex

Card Number:

Expiration Date:

(No dashes between numbers)

Name as Shown on Payment Card:

Billing Address of Cardholder:

City:

State:

Zip:

Office Phone:

Mailing Address of Cardholder:

City:

State:

Zip:

(If different from billing address)

Cardholder Signature:

Date:

Please complete and return this form *with your license application and all necessary documents* if paying by credit card. Or return the application and payment (this credit card form or check or money order) to the address listed below. PLEASE NOTE: If faxing the credit card, do not mail as you may be charged twice.

Mail to:

**Arizona Regulatory Board of Physician Assistants
9545 East Doubletree Ranch Road
Scottsdale, AZ 85258**

Or Fax to: 480-551-2707